



# Hypercholesterolemia

Ph: (214) 919-2090 or (877) 753-6878

Fax: 1 (888) 294-9434

Injection Training:  MD Office  
 Pharmacy to Arrange

Ship To :  Patient Home  MD Office

**MAIN POINT OF CONTACT**

Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**PATIENT INFORMATION (Use this area or attach patient demographics)**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Phone 2: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 ID#: \_\_\_\_\_ RxBin: \_\_\_\_\_ ID#: \_\_\_\_\_ RxBin: \_\_\_\_\_  
 RxGroup: \_\_\_\_\_ Pcn: \_\_\_\_\_ RxGroup: \_\_\_\_\_ Pcn: \_\_\_\_\_

**MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)**

Primary ICD-10: (select one)

- E78.0 Pure Hypercholesterolemia (including HeFH & HoFH)
- E78.2 Mixed Hyperlipidemia
- E78.4 Other Hyperlipidemia
- E78.5 Hyperlipidemia, unspecified

Secondary ICD-10: (select all that apply)

- I20.0 Unstable Angina
- I20.9 Angina Pectoris
- I21.\_ Acute Myocardial Infarction
- I22.\_ Subsequent Myocardial Infarction
- I25.\_ Chronic Ischemic Heart Disease
- I63.\_ Cerebral Infarction
- I65.\_ Occlusion & stenosis of Cerebral Arteries, Intracranial
- I67.\_ Other Cerebrovascular Diseases
- Other, Specify ICD-10 \_\_\_\_\_

**Rx** **Allergies:**

Medication	Strength	Directions	Qty.	Refills
Repatha	<input type="checkbox"/> 140 mg/ml PFS	<input type="checkbox"/> Inject 140 mg sub-Q every 2 weeks		
	<input type="checkbox"/> 140 mg/ml Sureclick	<input type="checkbox"/> Inject 420 mg sub-Q every 4 weeks		
Praluent	<input type="checkbox"/> 75 mg/ml Pen <input type="checkbox"/> 150 mg/ml Pen	<input type="checkbox"/> Inject subcutaneously every 2 weeks	<input type="checkbox"/> 1 month supply	
	<input type="checkbox"/> 75 mg/ml PFS <input type="checkbox"/> 150 mg/ml PFS	Other: _____	Other: _____	

Additional Drugs:

**ALL controlled substance quantities must be hand written in number and letter form**

Prescriber Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**\*Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Please fax completed form to 1 (888) 294-9434**